PROMISING PRACTICES IN HOME AND COMMUNITY-BASED SERVICES

South Carolina –Improving Responsiveness of Service Managers to Persons' Needs

Issue: Reminders of LTC Needs in Computerized Service Plan

Summary

This report describes how the State of South Carolina is addressing a problem of inconsistency between an individual's needs and the service plans developed to meet identified needs. South Carolina added a feature to its automated Case Management System (CMS) that reminds case managers of needs identified in the assessment that may potentially be included in the service plan. This feature enables case managers to document how services address an individual's particular needs.

Introduction

All individuals receiving assistance from Medicaid home and community-based services waivers undergo a comprehensive assessment to identify their need for services. Case managers and individuals then develop a plan of care to address these needs. In South Carolina, quality assurance reviews found that some consumers' plans of care failed to address needs that had been identified in the assessment process. As a result, persons may not have been receiving certain services that could help them live safely and independently in the community.

This report briefly describes an innovation adopted to improve service quality by helping to ensure that plans of care (which South Carolina calls service plans) include all of the needs identified in assessments. It describes the pre-existing automated management information system, the innovation and how it was implemented, and how results will be measured. This document is based on written materials about South Carolina's management information system, interviews with state staff that implemented the system change, and an interview with a local program administrator.

Background

South Carolina created an automated case management system in 1991 to help its case managers administer several long-term care programs. The internally-developed Case Management System (CMS) is a Microsoft Access application. By 2002, CMS databases were maintained daily by the state's 14 Regional Offices, with updates to the Central Office occurring nightly. South Carolina is planning to move toward a centralized database with secured Web access, which will allow instant database updates.

CMS includes information from assessments and service plans for Medicaid home and community-based services waivers that serve older people, people with disabilities, people with HIV and/or AIDS, and ventilator dependent people. The service plan includes information on the reasons a person may need long-term care services (the "problems"), the preferred result for the person related to the problems (the "goals"), and the means to reach the goals (the "intervention"). For example, if information gathered during the assessment indicates a person is unable to maneuver in a wheelchair in his or her home, a goal may be safe mobility, and the intervention may be a home modification to make the home more accessible.

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Case managers enter service plans and information obtained during assessments into CMS. Originally, case managers could not view the assessment information when entering the service plan. Case managers had to flip through several pages of a paper assessment tool or constantly refer back to the assessment data in CMS. Either process duplicated the work the case manager had done when entering assessment information. It also increased the chance that assessment information was not used to develop the service plan.

Intervention

To reduce this duplication, South Carolina in February 2001 implemented automated reminders, which it calls "triggers," between the assessment information in CMS and the service plan. Now case managers do not have to refer to the assessment tool to identify a person's long-term care needs.

After a case manager enters assessment information, the triggers automatically display problems in the service plan indicated by the assessment data. If a service plan had already been entered for a person (i.e., when a person receives a reassessment), the case manager can either copy the old service plan or create a new one. A new service plan identifies problems indicated by the current assessment data. If the old service plan is copied, CMS identifies which problems indicated by current assessment information were not in the previous service plan.

The triggers automatically display problems in the service plan indicated by the assessment data.

While the problems are displayed, if the case manager clicks on a problem, the assessment information linked to that problem is displayed. For example, if the case manager clicks on the problem indicating the consumer needs assistance with transportation, CMS displays the assessment information related to the person's transportation needs.

As might be anticipated with an automated system, in some instances the problems displayed by CMS might not completely or accurately represent a person's long-term care needs. The case manager can then add or remove problems to the service plan to reflect the person's individual circumstances. A few problems are labeled "required". If the triggers display these problems, the case manager must show how the problem will be addressed or document that there is an unmet need. For example, if a person needs help preparing meals, the case manager must identify the source of meal preparation assistance or document the person is receiving no formal or informal assistance for meal preparation.

Once the case manager approves the generated list of problems, CMS then displays system-defined "goals" and possible "interventions" for each problem. For example, adequate food supply may be a goal for a person unable to shop for groceries. Possible interventions could include an informal caregiver bringing groceries, home delivered meals paid by a waiver, or "unmet need" if a person refuses assistance. The case manager selects one or more of these interventions to indicate how the case manager and the consumer plan to address each problem.

Implementation

The estimated cost for implementing the triggers was $8,000 to $11,000, including computer programming time, identification of appropriate triggers, and local staff training. Programming took an estimated two weeks of dedicated programmer time, and three weeks of time from other staff.

Implementation of the trigger system may have been easier for South Carolina than it would be for other states, in part because case managers have entered service plans electronically for years. Case managers have a longstanding familiarity with the problems/goals/interventions concepts used in CMS. Local staff, including case managers and information system staff, had opportunities to give input on creating triggers through several standing statewide committees.

Impact

Anecdotal information from local supervisors suggests that the triggers have improved the connection between assessment information and services provided. Supervisors at South Carolina's 14 local offices check a random sample of service plans monthly to establish whether service plans address persons' long-term care needs as identified in the assessment. Local supervisors report on the percentage of service plans that do not match assessment information. State staff also monitor the data as part of their evaluation of case management services. Feedback from local administrators suggests that this quality innovation also saves time for case managers.

Contact Information

For more information about the triggers, please contact Roy Smith or Maria Patton, Directors of South Carolina's Community Long-Term Care Program, at (803) 898-2590. Their email addresses are SmithRoy@dhhs.state.sc.us and Patton@dhhs.state.sc.us, respectively. South Carolina's long-term care programs website is http://www.dhhs.state.sc.us/InsideDHHS/Bureaus/BureauofLongTermCareServices/.

Some Discussion Questions:

Do automatic triggers to link service plans with assessment information improve the quality of home and community based services?

For states without automated case management systems, how could the concept of "triggers" between assessment plans and plans of care be implemented?

One of a series of reports by Medstat for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in home and community-based services. The entire series is available online at CMS' web site, http://www.cms.hhs.gov/promisingpractices. This report is intended to share information about different approaches to offering home and community-based services. This report is not an endorsement of any practice.